***California Health Policy and Data Advisory Commission***
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**Minutes**
**California Health Policy and Data Advisory Commission**
**August 24, 2007**

The meeting was called to order by Vito Genna, Chair, at approximately 9:08 a.m., at the Tenaya Lodge, Fish Camp. A quorum of half of the members plus one was in attendance.

| **Present:** | **Absent:** |
|---|---|
| Vito J. Genna, Chairperson | Howard L. Harris, PhD |
| William Brien, MD | Kenneth M. Tiratira, MPA |
| Marjorie Fine, MD | Sol Lizerbram |
| Janet Greenfield, RN | Corrine Sanchez, Esq. |
| Adama Iwu | Josh Valdez, DBA |
| Jerry Royer, MD, MBA | |
| Sonia Moseley | |

**CHPDAC Staff:** Kathleen Maestas, Acting Executive Director; Terrence Nolan, Office Manager

**OSHPD Staff:** David M. Carlisle, MD, PhD, Director; Elizabeth Wied, Chief Counsel; Michael Rodrian, Deputy Director, Healthcare Information Division; Dale Flournoy, Deputy Director, Cal-Mortgage; George Fribance, Health Planning Specialist II, Cal-Mortgage; Joseph Parker, PhD, Health Quality and Analysis Division; Jonathan Teague, Manager, Healthcare Information Resources Center; Mary Tran, PhD, MPH, Administrative Data Programs; Candace Diamond, Manager, Patient Discharge Data Section; Starla Ledbetter, Data Management Office

Approval of Minutes: A motion was made by Commissioner Brien and seconded by Commissioner Moseley to approve the minutes of the June 22, 2007 meeting. The motion was carried.

Chairperson's Report: Vito Genna, Chair

Chairperson Genna stated that in the months since the last CHPDAC meeting the lack of a State budget has had a ripple effect on healthcare in the State, forcing many clinics to scramble with cash flow issues and some clinics to close. At the

time of the current meeting, a State budget has been passed which will start to take the pressure off many of the affected healthcare facilities.

AB 524 Technical Advisory Committee Report: Jerry Royer, MD, Chair

Commissioner Royer gave a detailed report on the most recent TAC meeting highlighting six agenda items:

- The July 12th release of the CABG (coronary artery by pass graft)
  - This represents the first OSHPD hospital and surgeon specific report
  - Four hospitals performed better than expected, six hospitals performed worse than expected
  - Four physicians performed better than expected, 12 performed worse than expected
  - The report was widely carried and discussed in the media

- The use of DNR (Do not resuscitate) in risk-adjusted models
  - In the early nineties DNR was added to the risk-adjustment model with the intention of improving the model
  - Recent publications indicate that DNR introduces systematic bias into hospital performance reporting
  - DNR does not necessarily address acuity, it may be much more representative of a quality of life choice
  - Since DNR is not a measure of severity of illness, adding DNR to the model makes hospitals with less ill patients appear to have more ill patients
  - Among options discussed were, continuing to use DNR, discontinuing the use of DNR and identifying a new data element to identify comfort care only
- The Patient Discharge Data Validation Study
  - Includes 48 hospitals and the review of 2,250 medical records
  - A nurse will validate POA (present on admission) and a coder will validate the reliability of the data elements
  - At present the study is 80 percent complete
- Expanding the Patient Discharge Data
  - The process of adding new data elements is currently in the definition stage
  - National standards will be used to the maximum extent possible
  - A phased implementation is anticipated
- Hospital Benchmark Reports
  - The alternative proposed approach to hospital and mortality reporting, Hospital Benchmark Reporting was discussed highlighting the first two proposed studies: congestive heart failure and AAA (aortic abdominal aneurism repair)
  - Rather than the traditional outcome report which has taken up to four years to produce, the benchmark report would be a brief technical report relying on AHRQ (Agency for Healthcare Reporting and Quality) IQI's (inpatient quality indicators) as a starting point

- o These reports would be based on risk-adjusted mortality rates with hospitals divided into quintiles as opposed to using statistical tests to identify outliers
- o The idea behind the benchmark report is to have more timely reporting, up to 16 months earlier, that contains more current and actionable data

OSHPD Director's Report: David M. Carlisle, MD, PhD, Director, OSHPD

OSHPD Director, Dr. Carlisle, reported that the State is fortunate to have passed a budget, ending what was the third longest budget process in California history. It is important to note that OSHPD is primarily a special fund supported department and therefore the lack of a State budget does not affect OSHPD programs directly, but does have an impact on OSHPD's ability to pay vendors, to pay contractors and to initiate new contracts.

Contrary to some reports that have stated that healthcare reform has been tripped up by the budget delay, Dr. Carlisle stated that healthcare reform is still moving forward and is priority number one for the Governor. The goal, in contrasting the Governor's proposal to other proposals being presented, is universal health coverage and health insurance access. Relevant to OSHPD within healthcare reform is the increased emphasis on reporting of quality care outcomes and cost of care. The Office, among some others, has been singled out as a vehicle for this kind of reporting.

Dr. Carlisle asked the Commission and its Committees to continue to encourage OSHPD to move forward in a variety of ways. Dr. Carlisle considers the benchmark reports a real step forward and the ability to leverage what AHRQ has done in terms of inpatient quality indicators a great opportunity. A sustained energy and vigor will be seen coming from the Office in terms of new products in the very near future.

The release of the CABG report represents a real landmark for the Office. It is hoped that the increased emphasis on transparency, in terms of results, will drive improvements in quality of care. With respect to the surgeon specific section of the report, Dr. Carlisle stated that there was a very complex and deliberate process in place to assure that reputations were not being unduly and unfairly damaged; recognizing that a bad score on a report like this can have a significant impact on an individual's career.

Commissioner Fine stated that the complaint she heard from people, in reading the report, was that they expected a broader dispersal of information, rather than as expected, more, or less. They wanted quintiles or some other finer gradations reported.

Dr. Carlisle explained that the statute pertaining to the study specifically calls for three categories of outcomes, and the two outlier categories are defined statistically. Because of the importance of stratifying people, and the importance of what strata they fall into, the Office wanted to be very conservative and use a pretty strict definition for outliers.

Commissioner Greenfield asked if, since the report was rating by doctor, the Office expected to see those doctors that rated well below, to move to a location that is not reporting.

Dr. Carlisle cited a study that came out of New York that provided analysis of what transpired with surgeons post-public reporting. Some surgeons retired, and some stopped performing CABG but continued doing other types of surgery. The whole point of the CABG report is to drive mortality down and drive outcomes up for this procedure, and there are a variety of ways that can be accomplished.

Commissioner Brien observed that the higher mortality rate by a given surgeon may be how he puts a stitch in, or his technique, but it also can represent assistance issues for that surgeon in the operating room or for the institution. This data is actually multi-focal.

Dr. Carlisle stated that was exactly why OSHPD did the surgeon by hospital analysis. OSHPD recognizes that the surgeon is only one component in the outcomes for patients undergoing this particular procedure. There is the anesthesiologist, the recovery room team, and everything that happens to the patient in the 30 days after they leave the hospital. These are all factors and they are important to keep in mind when you look at this procedure.

Dr. Parker added as a follow up that OSHPD is currently doing an analysis, which might be published in the coming months, that looks at that interaction between the surgeon and the hospital. What the analyses suggest to date is that high volume surgeons, performing in high volume hospitals seem to do quite well. However, high volume surgeons, when performing at low volume hospitals, don't do better than low volume, poor performing surgeons. So there is an important system effect there.

Legislative Update: David M. Carlisle, MD, PhD, Director, OSHPD

The Office has been monitoring 12 pieces of legislation and roughly half of them are significant for OSHPD.

AB 10, by Assembly Member De La Torre is of interest because it makes bond funding available specifically for children's hospitals. At this point it is unclear how far this will move and whether it will become a two year bill or just stop.

AB 611, by Assembly Member Nakanishi, would establish a physician assistant education loan program within the California Health Professions Education Foundation. The program may be difficult to implement as this would be a voluntary program, and the physician assistants would not be required to contribute to the fund. This bill is moving forward.

AB 1559, by Assembly Member Berryhill, would require a community college district governing board to adopt and implement a merit based admissions policy for an associate degree nursing program if, for any academic term, there are more applicants seeking enrollment than can reasonably accommodated. This bill is moving forward.

SB 139, by Senator Scott, would create a Healthcare Workforce Clearinghouse. The clearinghouse, to be administered by the Office of Statewide Health Planning and Development (OSHPD), would serve as the central source of healthcare workforce data in California. OSHPD would collect, analyze, and distribute information on educational

and employment trends for healthcare occupations in the State. This would give policymakers a better understanding of healthcare professions and education in meeting future needs. Currently this bill is suspended, but the Office expects it to continue to move forward in future sessions.

SB 211, by Senator Cox, would make it easier for hospitals to pay for and to receive accelerated plan review processes. This seismic safety bill is moving forward.

SB 306, by Senator Ducheny, contains a component that would allow OSHPD to develop a staged review process. OSHPD has discovered in a pilot project that construction moves faster if things are approved one step at a time. This bill speaks to the funding aspect, ensuring that we would receive appropriate funding. The bill is currently in the suspense fill, but the component that pertains to the Office is still moving forward.

SB 615, by Senator Oropeza, would require the board to collect an additional fee of $10 at the time a pharmacy license or pharmacy technician license is renewed to be deposited in the California Pharmacy Technician Scholarship and Loan Repayment Program Fund. This bill is moving forward.

SB 764, by Senator Migden, would require the Office to receive, and the Medical Board of California and the Osteopathic Medical Board of California to provide, information respecting individual board licentiates upon request by the Office. This bill is becoming a two year bill.

Report from Cal-Mortgage Loan Insurance Division: Dale Flourney, Deputy Director

Dale Flourney began his presentation by stating that California is unique in being the only state in the nation that amended its Constitution to create an insurance company inside government, similar to the FHA in relation to home mortgages. In 1968, the California voters passed an initiative that said that it made sense for the State of California to sell its credit rating to individual, non-profit healthcare providers, for the purpose of allowing those non-profit healthcare providers to borrow money at an interest rate equal to what the State of California was borrowing for its GO bond rate. If a project is needed and financially feasible, a nonprofit healthcare provider can purchase the State's credit rating. If the State's credit rating is better than the healthcare provider's credit rating, they will get a lower interest rate.

The Cal-mortgage Loan Insurance program's mission is to stimulate the flow of capital to needed healthcare facilities and to provide a loan insurance program without cost to the State. The loan insurance provides a guarantee of repayment, transfers lender risk to a third party, improves the credit quality of the borrower and lowers the borrower's interest rate.

Cal-mortgage has had only one major default in the program. In the early 1990's a corporation called NewMed decided to divest itself of a couple of hospitals in Los Angeles and a new company came in and bought those hospitals. Cal-mortgage insured the transaction and unfortunately the bond issue went south and the default caused

financial issues which are still being dealt with on a yearly basis. This kind of default has occurred only once in this program.

Dr. Carlisle stated that Cal-Mortgage is impacted by macro economic trends, as interest rates go up, Cal-Mortgage becomes more competitive, as the State's credit rating goes down, Cal-Mortgage becomes less competitive. The lack of a State budget and other market trends has currently affected Cal-Mortgages attractiveness but with the market liquidity drying up, Cal-Mortgages business should pick up.

The CHPDAC has historically played a role relating to hearings to validate or dispute staff decisions when an applicant has been denied. If an applicant thinks they have been unfairly denied, they can ask for a hearing. If they ask for a hearing, the CHPDAC sits as the hearing board to put Cal-Mortgage on trial with respect to whether or not Cal-Mortgage has made a reasonable business decision.

Report from Healthcare Information Division (HID): Michael Rodrian, Deputy Director

Michael Rodrian reported that HID is three-quarters through an aggressive modernization that will culminate with the Office relocation where staff will have completely new systems. Over the last two years there has been much done to address both the organizational structure and most importantly, computer systems at HID to insure that there is the needed infrastructure in place that the work HID does requires.

These improvements will ultimately make data more accurate and more accessible. Currently when a researcher wants to do some kind of analysis, a lot of time is spent converting the dataset into something that they want to use. HID has established a data warehouse and data morgue where annual files are prepared for access with statistical tools for researcher. Additionally modernizing the systems will assure that reporting happens seamlessly and with minimal downtime.

Healthcare Outcomes Center Report: Joseph Parker, PhD

Dr. Parker reported that the process for adding additional data elements to the Patient Discharge Dataset is currently in the definition stage. Information has been gathered from other states, and discussion have been held with CHART (California Hospital Assessment and Reporting Task Force) about their experiences with collecting data from hospitals for public reporting on quality.

Dr. Parker briefly presented the plans for data collection to the California Hospital Association's Quality Committee, on August 8th. Some of the concerns expressed by the Committee members were: the timeframe for the values, the possibility of having multiple values, and what data sources would be considered. They also wanted assurance that OSHPD was aware of other data collection initiatives that are going on within the hospitals so OSHPD could, to the extent possible, align definitions with those that are currently being used.

National standards will be used to the maximum extent possible as the process goes forward. OSHPD is thinking about a phased implementation. In terms of a time table,

OSHPD is planning on a May 2008 regulatory package, which would mean the regulations have been worked out and public hearings could begin. One of the requirements of the regulatory process is to have open public comment and the CHPDAC has been mentioned as a possible forum for public comments. The next quarterly update is scheduled to be given to the CHPDAC in December 2007.

Starla Ledbetter reported on the work being done in terms of communicating with hospitals and national standards for the POA (present on admission) indicator.

OSHPD actively participates in a number of national committees, consortiums and forums including:

- Public Health Data Standards Consortium
    - Work includes standardized payer typology and updates to the (HCSDRG) Healthcare Services Data Reporting Guide
- National Association of Health Data Organizations
    - OSHPD will attend the annual conference in October 2007 to present on POA and work being done by the Outcome Center
- X12 ANSI ASC Healthcare Claims Workgroup
    - Work includes adding Principal Language Spoken to HCSDRG and work on issues related to implementation of POA
- Public Health Informatics Joint Taskforce
    - Work includes moving towards unifying the public health voice for the advancement of electronic exchange of health data

The national standard for the POA indicator becomes effective October 1, 2007 and includes the following categories:

- Y=Yes
- N=No
- U=No information in the Record
- W=Clinically Undetermined
- 1=Not applicable

Not applicable applies to a list of ICD-9 codes that are exempt from reporting. There will also be a requirement for reporting POA on some external cause of injury codes. OSHPD currently just requires reporting of yes, no and uncertain on only principal and secondary diagnoses and not external cause of injury codes. CHIA (California Health Information Association) has voiced concern that the reporting was going to be very different between OSHPD and what the feds are requiring, so W and 1 will be allowed with discharges effective October 1, 2007.

OSHPD will also change the file format to allow for the collection of ICD-10 codes should pending legislation pass.

Candace Diamond reported that condition present at admission (CPAA) will be going to present on admission (POA) and the transition will be handled in two steps. First, in October, OSHPD will allow facilities to report the additional values but will not require

them. Second, when the regulation package hits in 2009, then Principal Language Spoken will be collected.

Report on OSHPD Data Users and Summary of How that Data is Used: Jonathan Teague, Manager II

OSHPD data is collected for 3 primary purposes for which it is used under law:

- Research
    - Typically university sponsored research institutions
- Public Health
    - Primarily through State agencies and local health departments
- Healthcare operations
    - California hospitals have broad access to information

In addition to the raw data, which is discharge data, emergency and ambulatory data, OSHPD also has product files that link these files with vital statistics data.

The research topic areas span subject areas from coronary and vascular disease, access to care, to queries on environmental and health issues including healthcare economics. OSHPD expects that as OSHPD's data resources becomes more widely known, and more easily accessed, other topic areas will be added to this list.

Commissioner Fine asked regarding the patient discharge data set and the 18 proposed data element if there was a clear attempt made to ascertain whether these data elements were indeed of interest to the research community.

Dr. Parker answered that there was a study done by Dr. Bindman that involved a lot of focus groups, and involved the research community, in particular and their feedback, along with feedback from hospitals was used in generating the initial list of proposed data elements. Jonathan Teague added that there are some clear and present reasons why OSHPD is looking for new data elements. Prospectively, there is inherently an element of speculative value. It is safe to say that until the administrative data was available, there were a lot of research studies that could not be done. When the new data elements are available there will be a lot of research opportunities that can only be dimly envisioned at this point.

Presentation of OSHPD's New Website: Jonathan Teague, Manager II

Jonathan Teague reported that the OSHPD website redesign is part of a statewide upgrade to web presentation and information provided to the public by the State government. The driver behind this overall upgrade is improving accessibility, via the web, to State resources and data, in keeping with the Americans For Disabilities Act guidelines, the Department of Rehab guideline, and statutes. There is also a strong push by the State Chief Information Officer to improve the usability and findability of our data, and put the information architecture into a form that is oriented towards the user's needs.

OSHPD is integrating services that are being deployed on a service oriented architecture basis throughout the State websites. The prime example of this is the Google search engine, which will dramatically enhance the findability of data on OSHPD's website.

Jonathan Teague stated that the website redesign project is going very well and should be on target for the State wide deadline of November, 2007.

Presentation on Patient Profile 2005: Mary Tran, PhD, HOC

Dr. Tran stated that the profile report is intended to be a general map of the landscape of healthcare in the State of California, particularly characteristics of the patients, their demographics, their geographics, their diagnoses, and procedures. The report contains background information that pertains to many of the topics that have been discussed at the present meeting. The report does not address hypothesis, emergent policy issues or outcomes, it provides information.

The data sources for 2005 are inpatient admissions from the patient discharge data (PDD) and outpatient encounters from the new emergency department (ED) and ambulatory patient data (ASC). For ED visits, which means the patient came in, was treated and went home, there are eight and a half million records. For ASC collected, there are 4.7 million records in 2005 from the hospitals associated, and about a million from the free standing facilities.

Dr. Tran showed a number of charts illustrating ED admissions and utilization broken down by various characteristics. For example, inpatient admissions, where the patients were living prior to admission, residential care and skilled nursing facilities (SNF) had the highest admission rate via the ED. Females use the ED more often than males when broken down by gender alone. When broken down by race/ethnicity, African Americans use the ED most, followed by White and Native American. The age breakdown for ED utilization shows the 0-5 group with the highest utilization followed by 16-35 and 65+. The county breakdown of ED utilization shows that the highest rates occur in rural and frontier areas of the State. Dr. Tran stated that this kind of information shows in a graphic way how ED closures in rural areas would have a disproportionately big effect on the population.

The top ten diagnoses and top ten procedures are also included in the report. The top ten diagnoses are shown by grouping the ICD-9 codes, using clinical classification software and the procedures are grouped using ICD-9 procedure codes for inpatient, and current procedural terminology (CPT) for outpatient procedures. The diagnoses and procedures are presented in the report in a variety of extensive tables broken down by age and race/ethnicity of which Dr. Tran presented a few to show the breadth of the reports information.

Chairperson Genna asked if this information would be released in a similar fashion to the fact booklets that have been issued previously.

Dr. Tran answered that the current thought on how the report would be released is to have it available on the web. It would not be a length report with numerous pages but if a person wanted to find out about payer source as an example, they could select age versus sex, click on that and get the Excel tables with the actual numbers.

Next Meeting: The next meeting will be held on October 12 in Southern California.

Adjournment: The meeting adjourned at 1:16 p.m.

Pending Items:

1. The Atlas II product will be demonstrated at the next CHPDAC meeting
2. Follow-up report on POA, patient discharge data, emergency department data, and ambulatory surgery data will be given at the November TAC and the December CHPDAC
3. Regulatory package for the additional data elements should be completed by May and public hearings would begin with CHPDAC suggested as a forum
4. The next quarterly report on the progress of the new data elements will be given at the December CHPDAC